MRI SCREENING QUESTIONNAIRE

Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Referring Physician: _____

Procedure: _____

Surgical History:

Head/Brain: _____

Neck/Chest: _____

Spine: _____

Bone/Joint: _____

Abdomen/Pelvis: _____

Have you ever been diagnosed with:

Cancer	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Seizures	❑ Yes ❑ No	Asthma/COPD	❑ Yes ❑ No

Any possibility you could be pregnant? ❑ Yes ❑ No

Are you allergic to anything (including contrast medium or dye)? ❑ Yes ❑ No

If yes, please list:

_____

Technologist Use Only

Contrast Type: _____

Amount: _____ Lot: _____ Exp: _____

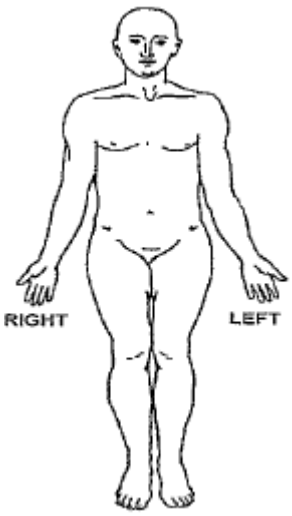
Creatinine: _____ GER: _____ Date Collected: _____

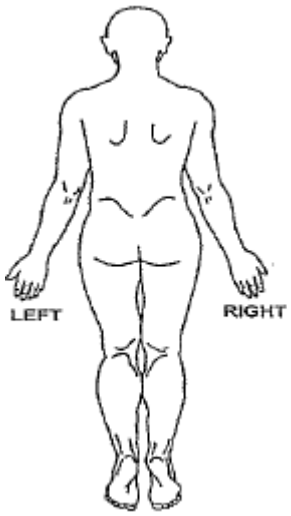
Physician Signature: _____

Time Out: ❑ Correct Patient ❑ Correct Procedure ❑ Correct Site

	**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Do you have any of the following?	**NO**	**YES**
• Pacemaker/ Defibrillator	❑	❑
• Brain or Aneurysm Clips	❑	❑
• Stents, Grafts or Filters	❑	❑
• Heart Valves	❑	❑
• Insulin or other Infusion Pumps/Devices	❑	❑
• Shunts	❑	❑
• Stimulators (bone, neuron, etc.)	❑	❑
• Hearing Aids or Ear Implants	❑	❑
• Metallic Fragments or Foreign Bodies (shrapnel, bullets, metal shavings, etc.)	❑	❑
• Bladder or Gastric Pacemaker	❑	❑
• Internal Electrodes or Wires	❑	❑
• Electronically, Mechanically or Magnetically Activated Devices	❑	❑
• Transdermal/Medication Patch (nicotine, nitroglycerin, birth control, etc.)	❑	❑
• Metallic Implants, Prosthetics, or Prosthesis (eye, limb, joint, penile, etc.)	❑	❑
• Metallic Staples, Clips, Sutures or Mesh	❑	❑
• Partials or Dentures	❑	❑
• Body Piercings or Tattoos	❑	❑
• Other implants or devices	❑	❑





I attest that the above information is correct to the best of my knowledge. I also give consent to have a contrast agent administered to me if needed for proper diagnoses of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form and the MRI procedure.

Patient or Responsible Party Signature: _____

Technologist Signature: _____

Date: _____

Sonos Imaging

Patient Demographics

Name: _____ DOB: _____ SS#: _____

Address: _____
PO Box or Street Address City State Zip Code

Phone Numbers: Home: _____ Cell: _____

Email Address: _____

How would you like for us to contact you? * ❑Phone ❑Email
*Please see the Credit Card on File Policy and Automated Call Authorization for information on how you will be contacted regarding payment.

Gender: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Primary Language:
❑English ❑Spanish ❑Other: _____

Race: (please check all that apply)
❑White ❑Black or African American ❑Asian
❑American Indian or Alaska Native ❑Native Hawaiian or Other Pacific Islander

Ethnicity:
❑Hispanic or Latino ❑Not Hispanic or Latino

Employer Information

Company Name: _____ Work#: _____

Address: _____
Street Address City State Zip Code

Insurance Information

Primary Insurance:_____ Secondary Insurance:_____

Policy#: _____ Policy#: _____

Group#: _____ Group#: _____

Insured Name: _____ Insured Name: _____

DOB: _____ DOB: _____

Please list any person(s) who may be used as an emergency contact.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

Is your visit today related to an injury or accident? ❑Yes ❑No
(If yes please complete section below)

Injury due to: ❑Work ❑Auto ❑Trauma ❑Slip/Fall

Date of Injury: _____Time of Injury: _____

Location of Injury: examples (home, skiing, walking, etc.) _____

What part of your body was injured? (be specific)_____

Have you been receiving treatment for this injury? ❑Yes ❑No

If yes, who is the doctor treating you for the injury? _____

Patient Signature: _____ Date: _____

Sonos Imaging

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Authorization applies to uses of Protected Health Information that are <u>not</u> for treatment, health care operations, payment, or otherwise as required by law. <u>Please review the Notice of Privacy Practices</u>.

PATIENT NAME: _____

DATE OF BIRTH: _____ **SSN:** _____

PATIENT ADDRESS: _____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of the use and disclosure:

_____

_____

Information that *may not be used or disclosed*:

_____

_____

The name or other specific identification of the person(s), or class of persons, to whom we may disclose such information:

_____

_____

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

_____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognized that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

_____

Sonos Imaging

Patient Name: _____ DOB: _____ DOS: _____

PLEASE READ AND INITIAL THE FOLLOWING:

_____ **CONSENT FOR MEDICAL TREATMENT**: I authorize the above referenced center (the "Center") to furnish the necessary medical and/or diagnostic procedure(s) ordered by my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures in the Center. I recognize that the physicians who practice at the Center are not employees of the Center but are independent physicians. The Center may delegate to these independent physicians those services physicians normally provide. Any questions related to my care should be directed to my physician.

_____ **ASSIGNMENT OF BENEFITS**: In the event I am, or the patient is, entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient (including Medicare, Medicaid and/or other third-party insurance benefits, supplemental, co-insurance and Medigap policies), I hereby assign said benefits to the Center for application on the patient's bill. I agree to be responsible for charges not covered by the assignment, including deductibles, co-payments, and denials of coverage.

_____ **CREDIT CARD ON FILE POLICY AND AUTOMATED CALL AUTHORIZATION**:

- I have received a copy of, and I understand and agree to all of the terms of, the Center's Credit Card on File Policy.
- I authorize the Center to keep my signature and valid credit card number securely on file.
- I agree to allow the Center or its agent to automatically charge my credit card for any outstanding balance, including but not limited to insurance denials for any reason, deductibles, co-insurances, partially paid claims, and any other charge my insurance carrier (or the insurance carrier that covers any individual whose payment of services I have accepted responsibility for, including as applicable my spouse, children, or other related party) has not or I have not already paid.
- I agree to allow the Center or its agent to charge my credit card if my insurance company delays or denies payment of any services or products the Center provides.
- I agree to promptly give the Center information for a new, valid credit if the credit card I have on file is expired, cancelled, or otherwise cannot be charged.
- I agree to give the Center correct contact information and to promptly update my contact information if any changes.
- I agree to allow the Center, or a third party acting on behalf of the Center, to contact me through any of the following means: by mail, by email, by telephone call (including calls made by an automatic telephone dialing system, and calls that may contain a pre-recorded message), and by text message.
- I understand and agree that the Center will use the contact information I provide and that is it my responsibility to control who has access to my mail, email, and telephone.
- I understand and agree that this authorization, including all the terms above, will continue to valid unless and until I cancel this authorization by providing the Center written notice that I am cancelling this authorization.

_____ **INFORMATION PRIVACY**: I have received the Center's Patient Bill of Rights and Notice of Privacy Practices.

_____ **RELEASE OF INFORMATION**: I hereby consent to the Center to releasing any information requested by the insurance company necessary to collect benefits on this claim. Unless noted below, this consent includes, but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric testing. I further authorize any physician or institution that attended this patient previously to furnish medical records or information that may be requested by the Center.

_____ **MEDICARE B SIGNATURE AUTHORIZATION**: I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of the Center, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and co-insurance.

_____ **WORKERS' COMPENSATION**: I authorize the Center to furnish written reports of my procedure to any representative, attorney for, or investigator from my Workers' Compensation carrier concerning injuries sustained as a result of accident occurring on _____/_____/_____.

_____ **IF PATIENT IS A MINOR**: I hereby give permission for _____ to be treated at the Center.

_____ **PERSONAL BELONGINGS**: I understand that I am personally responsible for my belongings and/or valuables that I have with me in the locker/dressing room or exam room. I will personally make sure I have everything with me before I leave the premises.

_____ **TRICARE/CHAMPUS PATIENTS**: I understand that Tricare is secondary to other insurance plans except for Medicaid and Tricare supplement plans. I agree to provide the Center with all insurance plans that I am currently enrolled so that benefits can be coordinated, and the appropriate authorizations can be obtained. I understand that failure to provide correct and accurate information may result in the patient in being responsible for entire balance.

NOTE: I understand that different insurance companies, payors, and health plans have different requirements for payment including, but not limited to pre-certification, authorizations, or notifications, timely filing of claims, or that the services be medically necessary as defined by the company, payor, or health plan. I understand that verification of benefits from the patient's insurance company is not a guarantee that services are covered or will be paid by the insurance company. I also understand that it is MY obligation to know the requirements of my health plan and ensure that they have been fulfilled.

I acknowledge that if I did not provide my insurance information today, or if it is not accurate, then I may be obligated to make full payment of all charges, and I will be charged in accordance with the Credit Card on File Policy set forth above. It will be my responsibility to file the claim with my insurance provider. If I provided the Center insurance information today, I am obligated to pay all co-payments, deductibles, and any non-covered out-of-network/reduced benefits at the time the services are rendered. I have an affirmative duty to make sure that payment and/or correct information for payment is given to the Center for reimbursement of services provided. I understand that there will be a fee of $45 for any returned check.

_____	_____
Patient/Guardian Signature	Date

PATIENT BILL OF RIGHTS

As an individual receiving services from Sonos Imaging ("Provider"), you have the following rights:

- Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care
- Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charged for which the client/ patient will be responsible
- Receive information about the scope of serviced that the organization will provide and specific limitations on those services
- Participate in the development and periodic revision of the plan of care
- Have one's property and person treated with respect, consideration and recognition of client/patient dignity and individuality
- Be able to identify visiting personnel members through proper identification
- Be free from mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of client/patient property
- Voice grievances/complaints regarding treatment of care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint,
- Voice grievances/complaints regarding treatment of care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, coercion, discrimination, or reprisal
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
- Confidentiality and privacy of all information contained in the client/ patient record and of Protected Health Information
- Be advised on the Provider's policies and procedures regarding disclosure of clinical records
- Choose a health care provider, including choosing an attending physician, if applicable
- Receive appropriate care without discrimination in accordance with physician orders, if applicable
- Be informed of any financial benefits when referred to an organization
- Be fully informed of one's responsibilities

PATIENT PRIVACY — Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective October 1, 2019

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. This Notice of Privacy Practices (this "Notice") describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other specified purposes that re permitted or required by law.
- This Notice also describes your rights with respect to your protected health information. "Protected health information" or "PHI" is information about you, including basic demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, and related health care services.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We are required to abide by the terms of our Notice currently in effect. We reserve the right to change to our privacy and security policies and procedures and this Notice, and to make the new Notice effective for all protected health information we maintain.
- We will post each revised Notice in our office(s), make copies of the revised Notice available upon request and post the revised Notice on our website.
- We will not use or share your information other than as described in the Notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

OUR USES AND DISCLOSURES

In general, we may not use or disclose your PHI without your written authorization. However, in certain circumstances, we are permitted to use your PHI without your written authorization. The following categories describe some of the ways that we may use and disclose your PHI without your written authorization.

We may use and disclose your PHI for treatment. We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including your referral to another health care provider.

Example: Your PHI will be recorded in your record and used to determine nature of the diagnostic imaging procedures required. We may also disclose PHI to doctors, nurses or other personnel outside our office who need the information to provide you with medical care.

We may use and disclose your PHI for health care operations. We may use or disclose your PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our business and to support our operations.

Example: We may use or disclose your PHI for quality assessment and improvement activities, such as making sure that patients receive quality services.

We may use and disclose your PHI for payment purposes. We may use or disclose your PHI to obtain payment or be reimbursed for the health care and related services we provide to you.

Example: We may disclose your PHI to health plans to determine coverage eligibility.

We may use or disclose your PHI as otherwise allowed by law. The following categories describe some different ways that we may use and disclose your PHI other than for treatment, payment or health care operations without your prior written authorization:

Help with public health and safety issues. We can share health information about you for certain situations such as:

- Preventing Disease
- Helping with product recalls
- Monitoring the performance of a product after of a product after it has been approved for use by the general public
- Reporting adverse events
- Reporting suspected abuse, neglect or domestic violence

- Preventing or reducing a serious threat to anyone's health or safety

Do Research. We can use or share information for health research.

Comply with the Law. We may use and disclose your health information when required to do so by federal, state or local law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers compensation claims or requests. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Disclosures to governmental agencies. Consistent with applicable law, we may disclose your health information for judicial, administrative or law enforcement purposes, or for intelligence and national security activities. We may additionally disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government benefit programs and compliance with applicable laws.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders/Treatment Alternatives/Health Benefits. We may use or disclose your PHI to provide you with appointment reminders (such as sending postcards or leaving a voicemail message, etc.) and to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if PHI is necessary for those functions or services.

Uses and Disclosures that require us to give you an opportunity to object. In certain circumstances we may not use or disclose your PHI without first providing you with an opportunity to agree or object. For example, we may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

All other uses and disclosures of your PHI require your written authorizations. The following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures of PHI not otherwise covered by this Notice or by applicable law.
- Uses and disclosures of PHI for marketing purposes
- Uses and disclosures of PHI that constitute a sale of your PHI
- Most uses and disclosures of psychotherapy notes

You may revoke such authorization in writing at any time; however, your revocation will not apply to any uses and disclosures that were being processed before we received your revocation.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

Restrictions. You have the right to request a restriction on certain uses and disclosures of your PHI for treatment, payment, or health care operations. You also have the right to request restrictions on certain disclosures to individuals involved in your care. However, we are not required to agree to your requested restriction. We are required to agree to your request only if (1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or healthcare operations (and not treatment purposes), and (2) your information pertains solely to health care items and services for which you or someone on your behalf have paid in full. If we do agree to your restriction, we will only use and disclose your PHI in accordance with such restriction, unless otherwise permitted or required by law. You may request a restriction by submitting your request in writing to the Practice.

Confidential Communications. You have the right to request that communications about your PHI be delivered by an alternative means or at alternative locations. For example, you may request that we contact you at your workplace about appointments. You must make such requests in writing and must specify how or where we are to contact you. We will accommodate reasonable requests.

Access. You have the right to inspect and obtain a copy of your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing, and we may charge you a reasonable, cost-based fee for labor and supplies needed to fulfill your request. Instead of copies we may provide you with a summary of your PHI, if you agree to the form and cost of such summary. We may, in some cases, deny your request and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial of your request reviewed. You may request to see and receive a copy of PHI by writing to us.

Amendments. You have the right to request an amendment to your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing and provide a reason to support the requested amendment. We may, in some cases, deny your request for amendment and will notify you in writing of the reasons for our denial, provide you with information regarding your rights to submit a written statement disagreeing with such denial and provide information on how to file such statement. You may request an amendment of your PHI by writing to us.

Accounting. You have the right to receive a listing of disclosures of your PHI made for purposes other than treatment, payment, health care operations, upon your request, your authorization, to individuals involved in your care or as allowed by law. You may request all such disclosures made during the last 6 years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to comply with your additional request. You may request a listing of disclosures by submitting your request in writing to us.

Notice of Security Breach. We are required to notify you if we discover a breach of your Unsecured PHI unless we are able to demonstrate that there is a low probability that the PHI has been compromised based on a risk assessment.

Electronic Notice. If you received this Notice by email or via our website, you have the right to receive a copy of this Notice in hard copy form upon your request. You may request a written copy of this Notice by contacting our business office.

QUESTIONS AND COMPLAINTS

If you have any questions, feel that your privacy rights have been violated by us, or want to exercise any of your rights described in this Notice, you may contact our Privacy Officer in writing at 1286 Oak Grove Road Suite 106, via telephone at 205-453-7525 or via email to info@sonosimaging.com. Due to federal and state privacy laws, we may not respond in detail to comments or complaints regarding us that are posted on a medical review website, social media outlet, or blog without your written authorization. If you have a negative experience or wish to express a complaint to us, we ask that you contact us directly to discuss and resolve the matter.

You may also submit a written complaint regarding our privacy practices to the U.S. Department of Health and Human Services Office for Civil Rights ("OCR"). We will not retaliate in any way against you if you choose to file a complaint with us or the OCR.

CREDIT CARD ON FILE POLICY

To our Patients:

Thank you for choosing Sonos Imaging to meet your healthcare needs. We are committed to providing you exceptional care and service, including making our billings process as simple and efficient as possible. To streamline our billings process, we have implemented a policy requiring all patients to leave a credit card on file. As you are likely aware, the current state of the healthcare market has resulted in significant changes in insurance plan's policies, co-pays, and deductibles. Some insurance plans require deductibles and copayments in amounts that cannot be readily determined at the time of your visit. Just like hotels and car rental agencies that require a credit card, we require a credit card on file to ensure we receive payment for our services and products.

Effective November 1, 2019, all patients will be asked for a credit or debit card (collectively, "credit card") at the time of your visit. You will be asked to swipe your credit card, and your information will be transmitted through a secure platform to AdvancedMD which will store your card information using a payment card industry compliant merchant system.

Frequently Asked Questions about the Credit Card on File Policy

Why are you implementing this policy?
Many insurance plans are placing more responsibility of payment on the patient. Often, the amount of a co-pay or deductible cannot be determined at the time of your visit. Placing a credit card on file allows us to ensure that we can obtain payment in a timely manner for the portions of your bill that are not covered by your insurance company.

Under what circumstances will you charge my card?
After today's visit, we will submit a claim to your insurance company. Once your insurance processes the claim, it will provide you and our office an Explanation of Benefits, which shows the amount covered under your plan and the amount, if any, you owe. Common examples of charges that your insurance carrier may not cover include co-payments, deductibles, co-insurance, non-covered services, and denied services. Your card will be charged only for amounts that your insurance plan did not cover that you did not already pay at the time of your visit, and only if you have not paid your remaining portion within 30 days after we receive the Explanation of Benefits. If you have applied for, and we determine that you qualify for, financial assistance, we will factor that into the amount your insurance company determines you owe, and you may owe a lesser amount or nothing. Similarly, if you have applied for, and we determine that you qualify for, a payment plan, the written payment plan we establish will control the when and how your credit card will be charged.

Will you notify me before you charge my charge?
Before your card is charged, we, or another party on our behalf, will attempt to notify you by mail, email, text message, or an automated telephone call that there is an outstanding balance, the amount of the balance, and that your credit card will be charged. It is your responsibility to make sure you provide us correct and current contact information. Calls to any telephone number provided to us may be made from an automatic telephone dialing system and may contain a prerecorded message. If you elect to provide a mobile or cellular phone number, check with your provider to make sure you understand how calls or text messages may be handled under your phone plan.

Do you charge me extra fees when you charge my card?
No. We do not charge any extra fees when we charge your credit card you have on file, as long as we are able to run your card. While your credit card company may charge any fees it normally does, we do not charge you extra.

What happens if the card on file expires or you otherwise cannot run my card?
If your card is expired, cancelled, or is otherwise declined, we reserve the right to charge a $35.00 declined card fee, which is similar to the fee we charge for returned checks, if you do not provide us a working card within 30 days. If your card is declined, we will call you at the number you provided to notify you and provide you the opportunity to provide a working card.

What are the benefits to me?
Instead of worrying about mailing in a payment, any amounts that you owe that are not paid at the time of your visit will automatically be charged to your card on file 30 days after we notify you that there is an outstanding balance, if we have not already received payment for such amount.

Do I have to pay with the credit card on file?
No. Once you receive your Explanation of Benefits from your insurance company, you can submit payment to us by cash or check, so long as we receive your payment prior to the scheduled automatic charge (which will take place 30 days after we receive your Explanation of Benefits). Under no circumstances will you have to pay the same bill twice. In the unlikely event that this occurs and we do not notice it ourselves, please notify us and we will promptly issue you a refund.

What if I need to dispute my bill?
We will always work with you to determine if there has been a mistake on your bill, and we will refund you if we have made a billing error. We will only charge you the amount that we are instructed to by your insurance company in your Explanation of Benefits.

Will my information be secure?
We do not keep your credit card information in our office files. Your credit card information will be encrypted and stored securely by AdvancedMD, which uses a secure platform that is both PCI DSS and HIPAA-compliant. A copy of AdvancedMD's privacy/security policy is available at http://info.advancedmd.com/rs/332-PCG-555/images/AdvancedMD-Online-Privacy-Statement.pdf.

What does "encrypted" mean?
AdvancedMD is required to encrypt your credit card information in accordance with the Payment Card Industry Data Security Standards (PCI DSS). The PCI DSS encryption standards incorporate industry leading security standards and best practices for safeguarding electronic information. While, practically speaking, no data is 100% secure, the PCI DSS security standards are designed to ensure that your credit card information will be maintained in a secure environment.

I always pay my bills on time. Why do I have to do this?
All patients are required to keep a credit card on file. This policy is not personal. We apply it equally to all of our patients. Although nearly all of our patients pay their bills in full and in a timely manner, not everyone does. A substantial amount of resources are devoted to collecting payments from a small number of patients, and this can drive up the cost for all of our patients. We want to avoid this, and we want to focus our attention and efforts on being the best healthcare provider we can be.

I've never had to do this before, here or at any other healthcare provider. So why now?
This may be different from what you have experienced in the past, but this is not an uncommon practice. Many healthcare providers are beginning to require a credit card on file for the same reasons we are now requiring it.

What if I don't have a credit card?
If you do not have a credit card, you can pay with cash or check for the visit in full. Then, if we receive payment from your insurance plan, we will promptly refund you the amount your insurance plan covered.

My insurance covers 100%, so there will never be a charge.
Just like everyone else, you will be required to comply with the Credit Card on File Policy. If your insurance plan or plans do in fact cover the full amount and instruct us that you owe nothing, your card will not be charged.

Who can I talk to about this policy?
If you have questions at any time about the Credit Card on File policy, please contact us by calling us or visiting us in person, and our staff will

direct you to the most appropriate person who can answer your questions.